53800. General Provisions.

(a) In regions designated by the department, health care services to eligible Medi-Cal beneficiaries shall be provided through no more than two prepaid health plans.

(b) The two prepaid health plans in the designated regions shall be selected as follows:

(1) The department shall award one contract through a competitive bid process.

(2) The department shall award one contract to a prepaid health plan which is:

(A) Organized by the county government(s) or by stakeholders of a region designated by the director under the Two-Plan Model, or

(B) Designated by the county government(s) or by stakeholders of a region designated by the director under the Two-Plan Model, and approved by the department at the department's sole discretion.

(C) As a condition of contract award, the prepaid health plan shall agree:

(1) To include in its health care delivery system under the contract any safety net provider as defined in subsection 53810(hh) physically located and operating within the designated region, as defined in subsection 53810(m), that is willing to agree to provide services under the same terms and conditions that the plan requires of any other similar provider to be included in the health care delivery system under the contract, and

(2) To establish participation standards for any provider of medical or hospital services, physically located and operating within the region, that will ensure the opportunity for substantial participation of traditional Medi-Cal providers, as defined in subsection 53810(jj), in the health care delivery system under the contract. Nothing in this subsection shall be construed to prevent federally qualified health centers from requesting cost-based reimbursement consistent with federal law in seeking to enter into a subcontracting relationship with a plan in a designated region.

(3) If no health care service plan is willing or able to contract with the department pursuant to subsection (2), the department may award two contracts pursuant to subsection (1). The two prepaid health plans shall agree to offer subcontracts to safety net providers physically located and operating within the designated region in accordance with policies developed by each prepaid health plan and approved by the department prior to commencement of plan operation.

53810. Definitions.

The following definitions shall be used throughout this chapter unless the context requires otherwise.
(a) Affiliate means an organization or person that, directly or indirectly through one or more intermediaries, controls, or is controlled by or is under common control with, a plan, and that provides services to, or receives services from, a plan.

(b) American Indian means any person who is eligible under federal law to receive health services provided directly by the United States Department of Health and Human Services, Indian Health Service (IHS) or by a tribal or urban Indian health program funded by IHS to provide health services to eligible individuals either directly or by contract. The definition includes members of an American Indian's household.

(c) Assignment means the actions taken by the Health Care Options Program to enroll an eligible beneficiary into a plan, in the absence of a selection made by the beneficiary. Assignment also means action by a plan to assign a member to a primary care physician in the absence of a selection made by the member.

(d) Capitated service means a medical service for which a plan is compensated in its fixed monthly per member rate.

(e) Caseload means the number of Medi-Cal beneficiaries in mandatory aid categories in a given month.

(f) Case Management means services provided by a primary care provider/physician to ensure the coordination of medically necessary health care services, assuring the provision of preventive services in accordance with established standards and periodicity schedules and ensuring continuity of care for Medi-Cal members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

(g) Commercial plan means the prepaid health plan in a designated region awarded a contract by the department pursuant to section 53800(b)(1).

(h) Commercial plan enrollment maximum means the enrollment level established by the department pursuant to section 53820(b).

(i) Contract means the written agreement entered into between a prepaid health plan and the department to provide health care services to plan members in a designated region.

(j) Contract maximum means the maximum enrollment level established by the terms of a prepaid health plan or PCCM plan contract.

(k) Contracted capacity means the number of Medi-Cal beneficiaries in the mandatory aid categories a prepaid health plan has either contracted with the department to enroll and serve in a region, or has committed to enter a prepaid health plan contract with the department to enroll and serve in a region.

(l) Department means the Department of Health Services.

(m) Designated region means that geographic area designated by the director within which a plan is approved by the department to provide services to Medi-Cal beneficiaries pursuant to a contract authorized by Welfare and Institutions Code Section 14087.3. The

designated regions shall be within, between, or among the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare, and any other county, with the approval of the Director, which may elect to participate in accordance with the provisions of this regulation.

(n) Disproportionate share hospital (DSH) means any hospital receiving payments as provided in Welfare and Institutions Code Section 14105.98.

(o) Eligible beneficiary means a person who resides in an area covered by the Two-Plan Model Managed Care Program, who has been determined eligible to receive Medi-Cal services, whose scope of Medi-Cal benefits is not limited, and meets the enrollment criteria as specified in section 53845.

(p) Enrollment level means the number of Medi-Cal beneficiaries enrolled in a plan.

(q) Fair hearing means an administrative hearing conducted by the State relating to Medi-Cal eligibility or benefits, pursuant to sections 50951 through 50955, 51014.1, 51014.2, and 53894.

(r) Federally qualified health means centers means an entity which:

(1) Is receiving a grant under section 330 of the Public Health Service Act; or

(2) Is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under section 330 of such Act; or

(3) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant; or

(4) Was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive federally funded health center as of January 1, 1990; and

(5) May be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

(s) Health Care Options Program means the entity providing Medi-Cal managed care and fee-for-service options presentations, managed care plan enrollment and disenrollment activities, and managed care related problem resolution functions in designated regions.

(t) Indian Health Service facility means a tribal or urban Indian organization operating health care programs or facilities with funds from the Department of Health and Human Services, IHS, appropriated pursuant to the Indian Health Care Improvement Act (25 U.S.C. section 1601) or the Snyder Act (25 U.S.C. section 13).

(u) Initial health assessment means an assessment conducted by the plan of a member's medical health status.

(v) Local initiative means the prepaid health plan which is organized by a county government or by county governments of a region designated by the director, or organized by stakeholders of the designated region, and awarded a contract by the department pursuant to section 53800(b)(2).

(w) Local initiative enrollment minimum means the total number of Medi-Cal beneficiaries in the mandatory aid categories in the designated geographic area less the maximum enrollment level established pursuant to section 53820.

(x) Mandatory aid categories means the Medi-Cal aid categories of Public Assistance-Aid to Families with Dependent Children, as described in section 1931 of the Social Security Act (42 United States Code, section 1396) as added by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Medically Needy-Family (Aid to Families with Dependent Children) with No Share of Cost, as described in section 1931 of the Social Security Act (42 United States Code, section 1396) as added by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and Medically Indigent Children with No Share of Cost, which will be required to enroll in a prepaid health plan under the two-plan model.

(y) Maximum enrollment means the maximum commercial plan enrollment level at which the commercial plan ceases to receive default assignment enrollments as provided under this Chapter.

(z) Member means an eligible beneficiary who is enrolled in a plan.

(aa) Nondesignated region means any geographic region of California other than a designated region or the counties of Orange, Sacramento, San Mateo, Santa Barbara, Santa Cruz, or Solano. Unless other geographic boundaries are established by the department, region shall mean a single county.

(bb) Ombudsman means the individual within the department who investigates and resolves complaints about managed care made by, or on behalf of, Medi-Cal beneficiaries.

(cc) Plan means a prepaid health plan that has entered into a contract with the department.

(dd) Prepaid Health Plan (PHP) means a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, which has entered into a contract with the department on a capitated rate basis to arranger for the provision of health services to eligible beneficiaries in a designated region.

(ee) Primary Care Case Management (PCCM) plan means a primary care provider or other entity who has entered into a contract to provide health care services under the provisions of article 2.9 commencing with section 14088, Welfare and Institutions Code.

(ff) Primary care physician means a physician who has the responsibility for providing, or for supervising nonphysician medical practitioners providing integrated services addressing a large majority of personal health care needs sustained over time; for maintaining and coordinating the continuity of member care, and for initiating referrals for specialist care. A primary care physician is a physician in general practice or is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner.

(gg) Primary care provider means a person responsible for coordinating and providing primary care to members, within the scope of their license to practice, for initiating

referrals and for maintaining continuity of care. A primary care provider may be a primary care physician or nonphysician medical practitioner including a nurse practitioner, certified nurse midwife or physician assistant.

(hh) Safety net provider means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider.

(ii) Service site means the location designated by a plan at which a member receives primary care physician services.

(jj) Traditional provider means any physician who has delivered services to Medi-Cal beneficiaries within the last six months; this notwithstanding, local initiatives or commercial plans may establish their own policies and participation standards for the inclusion of traditional providers in their provider networks. Policies and participation standards established pursuant to this subsection shall be consistent with those required under section 1915(b)(4) of the Social Security Act.

(kk) Transition period means, for each designated region, the period beginning April 1, 1993 through the date the two-plan model becomes operational in the region.

(ll) Two-plan model means the health care delivery system described in section 53800, which will consist, in most cases, of a commercial plan and a local initiative.

53820. Maximum Enrollment Levels.

(a) The department shall implement the two-plan model in regions designated by the department, pursuant to section 53800.

(b) For each designated region, the department shall establish a maximum enrollment level of Medi-Cal beneficiaries in the mandatory aid categories for the commercial plan under the two-plan model, which will consider the following factors:

(1) The number of inpatient days qualifying for DSH supplemental payments as the surrogate measure for services provided by all safety net providers in the region.

(2) The impact of the enrollment of Medi-Cal beneficiaries in the commercial plan on supplemental DSH payments, to the extent that inpatient days provided to members of the commercial plan will be diverted from safety net providers.

(3) The number of acute inpatient hospital days attributable to the Medi-Cal beneficiaries not enrolled in prepaid health plans or PCCM plans.

(4) The acute inpatient hospital utilization rate for Medi-Cal beneficiaries in the mandatory aid categories.

(5) The enrollment levels of both plans of the two-plan model necessary to ensure true beneficiary choice between plans and among providers within the two plans.

(6) The hospital inpatient care contracts the commercial plan may have with disproportionate share hospitals.

(7) An agreement between a local initiative and commercial plan in a designated region regarding local initiative minimum and commercial plan maximum enrollment levels.

(c) The process for setting the maximum enrollment level for the commercial plan in any region shall include the following:

(1) The department shall notify the Board(s) of Supervisors of each county included within the region of the proposed maximum enrollment level and the rationale for the proposed level.

(2) The Board(s) of Supervisors shall have 30 days to submit written comments to the department on the proposed maximum enrollment level.

(3) The department shall review and consider any written comments received from the Board(s) of Supervisors within the 30 day comment period and may adjust the maximum enrollment level, if the department determines that an adjustment is warranted, or may set the maximum enrollment level as originally proposed.

(d) The department shall reevaluate the maximum enrollment level at least every two years and revise the level, if appropriate.

(e) If the number of enrollees and the utilization patterns of the commercial plan have significantly reduced or will significantly reduce DSH supplemental payments in the region, the department shall require the commercial plan to contract with disproportionate share hospitals for inpatient care for members.

53830. Prepaid Health Plan and Primary Care Case Management Plan Enrollment Growth During the Transition Period.

(a) Until the implementation of the two-plan model in a designated region, the aggregate enrollment level of all prepaid health plans and PCCM plans affiliated with either the local initiative or the commercial plan operating in the region shall not exceed the maximum enrollment level for the commercial plan established by the department under section 53820(b) unless an exemption has been granted by the department pursuant to subsection (e). If the maximum enrollment level for the commercial plan in the region is exceeded and if the sum of the prepaid health plan contract maximums in the region is greater than the maximum enrollment level for the commercial plan in the region, the department shall negotiate amendments to the prepaid health plan contracts to set contract maximums specified to the region that will assist in bringing the total enrollment level in conformance with the maximum enrollment level for the commercial plan.

(b) Until the implementation of the Two-Plan Model in a designated region, the total allowable enrollment growth for PCCM plans in a designated region shall be the maximum enrollment level for the commercial plan set by the department for the region in accordance with section 53820(b) less the aggregate contracted capacity of all prepaid health plans operating in the region and less the total enrollment level of all PCCM plans operating in the region, unless an exemption has been granted by the department pursuant to subsection (e).

(1) If there is allowable enrollment growth in the region for PCCM plans, a PCCM plan's enrollment growth in a region shall not exceed the percentage growth in the caseload in the region, which shall be determined as follows:

(A) In June of each year, the department shall establish an aggregate caseload growth percentage factor for the subsequent six-month period in each region. The department shall recalculate and apply this factor in December of each year.

(B) Each PCCM plan's enrollment level in each region as of July 1 in each year shall be multiplied by the caseload growth percentage factor calculated in June for that region. The product of this calculation shall be the PCCM plan's maximum enrollment growth for the six-month period ending December 31 of that year. Each PCCM plan's maximum enrollment growth for the six-month period ending June 30 in each year shall be calculated in the same manner by the department, using the PCCM plan's enrollment level in each region as of January 1.

(C) Once a PCCM plan achieves its six-month maximum enrollment growth in a region, enrollments in that region shall not be accepted by the department for the remainder of the six-month period except as necessary to allow the PCCM plan to maintain its maximum enrollment level by replacing beneficiaries who disenroll from the PCCM plan.

(D) In calculating the aggregate caseload factor for each subsequent six-month period, the department may adjust this factor for any documented over- or underestimate of caseload growth in a region for the preceding caseload growth in a region for the preceding six-month period. Based on this adjustment, the department may further limit or increase PCCM maximum enrollment growth in the region for the succeeding six-month period.

(2) If the total allowable enrollment growth in the region is insufficient to allow all PCCM plans operating in a region to increase enrollment as provided in subsection (b)(1), the allowable increase shall be distributed equally among plans falling within the following priority categories, except that no plan may increase above the level provided by subsection (b)(1):

(A) Among PCCM plans whose most recent annual medical review by the department found no or only minor deficiencies in quality of care:

(i) First, PCCM plans whose most recent annual medical review by the department found a compliance level of 80 percent or better in the provision of Child Health and Disability Prevention services;

(ii) Second, PCCM plans whose most recent annual medical review by the department found a compliance level of 80 percent or better in the provision of adult preventive screens;

(iii) Third, all other PCCM plans whose most recent annual medical review by the department found no or only minor deficiencies in the quality of care; and then,

(B) All other PCCM plans in the region.

(c) If there is no allowable enrollment growth PCCM plans in a designated region, a PCCM plan's maximum enrollment level in that region shall be limited to its enrollment level as of the first month following the month in which the PCCM plan is notified to this effect.

(d) Until the department has established the commercial plan maximum enrollment level in a designated region as provided under section 53820(b), the maximum enrollment level for each PCCM plan in the designated region shall be capped at the plan's enrollment level as of July 1, 1993, unless an exemption has been granted by the department pursuant to subsection (e).

(e) The department may grant exemptions to the maximum enrollment level established for a PCCM plan pursuant to subsections (b) or (d) if special circumstances are established by the department. Special circumstances may specifically include, but are not limited to, a county Board of Supervisors, with the stated intention of including the PCCM plan or plans or the additional enrollment in the provider network of the local initiative, requesting the department to allow a PCCM plan or PCCM plans to enroll Medi-Cal beneficiaries above the maximum enrollment level established pursuant to subsections (b) or (d).

(f) PCCM plan enrollment growth in nondesignated regions shall be limited to caseload growth as described in subsection (b)(1) unless special circumstances are established by the department. Special circumstances may include:

(1) A county board of Supervisors asks the department to allow a PCCM plan or PCCM plans operating in the county to enroll Medi-Cal beneficiaries at a rate greater than caseload growth.

(2) The department identifies a problem with access to care in a region that can be met by PCCM plans enrolling Medi-Cal beneficiaries at a rate greater than caseload growth.

(3) A county Board of Supervisors proposes to develop a health care delivery system both for Medi-Cal beneficiaries and for medically indigent persons covered by the county's responsibilities under 17000 of the Welfare and Institutions Code, and intends to use a PCCM plan or PCCM plans in this system.

(g) PCCM plans shall be permitted to open new service sites, enlarge existing service areas, and add new service areas in nondesignated regions to the extent that the plans do not exceed the enrollment level authorized by this section.

(h) The department shall publish a public notice of its intent to approve a new service area or enlargement of a service area for a PCCM plan in nondesignated regions at least 60 days prior to the action. The notice shall appear in at least two major newspapers of general distribution in the proposed service area and shall provide instruction for submission of comments.

(i) Nothing in this section precludes the department from applying appropriate sanctions as provided in section 56350 or 56408 against PCCM plans.

(j) Nothing in this section authorizes a PCCM plan to enroll embers in excess of the plan's capacity to provide services to members under the terms of the plan's contract and all applicable laws and regulations.

53840. Two-Plan Model Requirements.

Each plan in a designated region shall:

(a) Obtain or maintain a license to operate as a Knox-Keene health care service plan, and meet all requirements set forth in Chapter 2.2 (commencing with Section 1340 of the Health and Safety Code) and related applicable regulatory requirements throughout the term of the contract between the plan and the department.

(b) Comply with all applicable federal and state statutory, regulatory, and administrative requirements, including, but not limited to, those organizational and administrative requirements contained in the Social Security Act and the Code of Federal Regulations.

(c) Comply with all standards, requirements and responsibilities stipulated and agreed to in the contract between the plan and the department including but not limited to:

(1) Organization.

(2) Legal Capacity.

(3) Administration/Staffing.

(4) Management Information System.

(5) Reporting Requirements.

(6) Quality Improvement System.

(7) Provider Network and Geographic Access, including a documented system for monitoring access to care.

(8) Scope of Services including preventive services for adults and all required CHDP and EPSDT services.

(9) Medical Standards/Health Education.

(10) Marketing and Enrollment.

(11) Member Services/Grievance System.

(12) Cultural and Linguistic Services Requirements.

(13) Financial Solvency.

53845. Enrollment Criteria.

(a) Enrollment in plans shall be mandatory for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope;

(2) Have been determined to have a share of cost equal to zero;

(3) Do not meet the criteria for exemption from plan enrollment, specified in section 53887;

(4) Have been determined by their county welfare department to be eligible for one of the following programs:

(A) The section 1931(b) Program, which consists of the services described in Welfare and Institutions Code section 14005.30, including persons whose Medi-Cal eligibility is based upon their receipt of benefits under the California Work Opportunity and Responsibility to Kids (CalWORKS) Program.

(B) The Medically Indigent program for children under age 21, as specified in section 50251(a).

(C) The Medically Needy Program for families and caretaker relatives, specified in sections 50203(a)(2) and (3).

(D) The Other Public Assistance Program as specified in section 50237, but excluding those in the In-Home Supportive Services category, section 50245.

(E) The Special Zero Share of Cost Program for infants, as specified in section 50262; for children of age one to age six, as specified in section 50262.5; and for children of age six to age nineteen, as specified in section 50262.6.

(F) The Transitional Medi-Cal Program as established in accordance with Section 1931 of the federal Social Security Act (Title 42, United States Code, section 1396 u-1) and described in Welfare and Institutions Code sections 14005.8 and 14005.81.

(b) Enrollment in a plan shall be voluntary for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope;

(2) Have been determined to have a share of cost equal to zero; and

(3) Have been determined by their county welfare department to be eligible for one of the following programs:

(A) The federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Title 42, United States Code, section 1382 et seq.) or who are deemed by the county welfare department to be Supplemental Security Income recipients in accordance with section 4913 of the federal Balanced Budget Act of 1997.

(B) The Medically Indigent Program for pregnant women, as specified in section 50251(b)(3).

(C) Foster Care Program as described in Article 5 (commencing with section 11400) Chapter 2, Part 3, Division 9 of the Welfare and Institutions Code.

(D) Adoption Assistance Program as described in Chapter 2.1 (commencing with section 16115) Part 4, Division 9 of the Welfare and Institutions Code.

(E) The Medically Needy Program for aged, blind and disabled beneficiaries, specified in section 50203(a)(1).

(F) The receipt of health care services through an Indian Health Service facility as defined in section 55100(j).

(G) The In-Home Supportive Services category, as specified in section 50245.

(c) Children receiving services under either the Foster Care or Adoptions Assistance Programs may be enrolled voluntarily if:

(1) The county Director of Social Services, or his or her delegated representative, determines that it is in the best interest of the child;

(2) The child's caretaker agrees to the enrollment; or

(3) The probation officer in the case of a foster child who is a ward of the court approves the enrollment.

(d) Where the department determines that it is feasible, and the conditions of subsection (c) are met, a child receiving services under the Foster Care or Adoptions Assistance Programs who physically resides in a designated region, but whose county of residence for the purpose of determining eligibility for the Medi-Cal program is part of another designated or nondesignated region, may be permitted to enroll in either of the two plans in the designated region in which the child physically resides.

(e) Beneficiaries enrolled in one of the following form of other health coverage shall not be enrolled in a Medi-Cal managed care plan:

(1) Medicare HMO,

(2) CHAMPUS Prime HMO,

(3) Kaiser HMO or

(4) Any other HMO or prepaid health plan in which the enrollee is limited to a prescribed panel of providers for comprehensive services.

(f) Beneficiaries with other coverage in an HMO, as specified in (e)(1), (3) or (4) above, may be enrolled in the Medi-Cal plan, as specified in section 53889, if:

(1) The Medi-Cal plan in which the eligible beneficiary is enrolling is the same as the HMO in which the beneficiary is enrolled, and

(2) Such enrollment is allowed in the contract between the plan and the department.

53850. Organization and Administration.

53851. Scope of Services.

(a) Each plan in a designated region shall provide or arrange for the provision of all Medi-Cal covered services to be delivered, unless excluded under the contract, in accordance with the terms and conditions of the contract between the plan and the department.

(b) The scope of services available to Medi-Cal members shall include:

(1) An initial health assessment, unless the member's primary care physician determines that the member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements stated below, and with the requirements of section 53840(c)(7). The assessment, at a minimum shall include, a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. The plan shall ensure that care for pregnant women is initiated at the earliest time possible.

(2) Health education.

(3) Preventive services.

(4) Primary and specialty care.

(5) Case management and coordination of care as defined in section 53810(f).

(6) Emergency care.

(c) Each plan shall refer and coordinate care for those services that are excluded under the contract, whether or not covered under the Medi-Cal program, pursuant to the requirements of the contract between the plan and the department.

(d) No plan shall withhold medically necessary Medi-Cal covered services not specifically excluded under the contract, due to a dispute with the department over capitation rates, service costs or any other reason. The plan shall pursue a remedy in accordance with the provisions of the contract.

(e) Each plan shall ensure that information, services or presentations required under this section, shall be provided in: language that is easy to understand, the preferred language of the beneficiary, a culturally appropriate manner, and a way that is fully accessible to beneficiaries with disabilities.

53852. Availability of Services.

Each plan in a designated region shall obtain written departmental approval prior to making any substantial change in the availability or location of services to be provided under the contract, except in the case of a natural disaster or emergency circumstances. A proposal to change the physical location at which covered services are provided, or to reduce or change the hours, days or location at which the services are available, shall be given to the department at least sixty days prior to the proposed effective date. The department's denial of the proposal shall prohibit implementation of the proposed

changes. The plan's proposal shall allow for timely notice to beneficiaries to allow them to change plans if desired.

53853. Accessibility of Services.

(a) Each plan in a designated region shall retain sufficient professional medical staff, including adequate numbers of specialists and subspecialists, to provide access to preventive and managed health care services to its members. Access to physicians or physician extenders shall be as follows:

(1) Each plan shall ensure its provider network satisfies a ratio of at least one full-time equivalent primary care physician for every 2,000 members.

(2) Each plan shall ensure its provider network satisfies a ratio of at least one full-time equivalent physician for every 1,200 plan members.

(3) Plans that utilize nonphysician medical practitioners shall not allow a full-time equivalent nonphysician medical practitioner to maintain a caseload of more than 1,000 plan members. The plan shall ensure compliance with title 22, CCR, sections 51240 and 51241.

(4) If utilized by a plan, members may select a nonphysician practitioner as their primary care provider. Nonphysician practitioners including certified nurse midwives, nurse practitioners and physicians assistants, shall meet the requirements of existing practice and licensure standards for mid-level practitioners, as specified in section 1399.541 and 1470, Title 16, CCR.

(b) Each plan in a region shall ensure that each member of the plan has a primary care physician to supervise and coordinate each member's health care, by either allowing members to select their primary care physicians or assigning members to primary care physicians, pursuant to section 53890.

(c) Each plan shall ensure that members have 24-hour access to interpreter services.

(d) Each plan shall ensure that other appropriate linguistic services are available to members pursuant to the contract between the plan and the department.

53854. Pharmaceutical Services and Prescribed Drugs.

(a) Each plan in a designated region shall at a minimum, make available to members during the hours of operation of each member's primary care service site, either directly or through subcontracts, the services of pharmacies and pharmacists in accordance with title 22, CCR, section 53214.

(1) Pharmaceutical services shall, at a minimum, be available to members during established service site hours.

(2) When the course of treatment provided to a member by a contracting provider under emergency circumstances requires the use of drugs, a sufficient quantity of such drugs will be provided to the member to last until the member can reasonably be expected to have a prescription filled.

(3) Plans shall establish and document the availability of after hours nonemergency pharmacy services. Plans shall make available by telephone information regarding the availability, location and hours of operation of pharmacies providing such services.

(b) Prescribed drugs shall be provided to members by licensed pharmacies and shall be reimbursed by the plan in which the member is enrolled. Professional standards reflected by reasonable and current prescribing practices, based on reference to current medical literature and consultation with provider organizations, academic and professional specialists, shall be met, including but not limited to Title 16, sections 1707.1, 1707.2, and 1707.3.

(c) Prescribed drugs may include the provision of pre-packaged drugs ordered by a physician and dispensed by a pharmacist or other appropriately licensed individuals affiliated with the plan after the plan has obtained written approval from the department to operate in this manner.

(d) Except for drugs specifically excluded from the contract, any drug covered by the Medi-Cal Program shall be available from the plan when medically necessary. This shall not be construed to require a plan to include in its formulary every drug listed on the Medi-Cal formulary, or to prevent a plan from performing appropriate utilization review to determine the most suitable drug therapy for a particular medical condition. . The plan shall not refuse to dispense or pay for Medi-Cal covered drugs, while pursuing the resolution of a dispute with the department over the plan's reimbursement for drugs, coverage of drugs, or for any other issue relating to covered drugs.

53855. Care Under Emergency Circumstances.

(a) Each plan in a designated region shall cover emergency medical services without prior authorization pursuant to title 10, CCR, section 1300.67(g) and title 22, CCR, section 53216. Each plan shall reimburse, without prior authorization, hospital emergency departments or emergency physicians for medical screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the plan member. If the medical screening examination indicates that the patient's condition does not constitute an emergency as defined in section 51056, hospital emergency departments or emergency physicians shall obtain prior authorization from the plan to render treatment. The plan may deny reimbursement for any services rendered to the member beyond the medical screening examination if the hospital emergency department or emergency physician fails to obtain prior authorization. Upon receipt of a request for such authorization from an emergency services provider, a plan shall render a decision upon the request within 30 minutes, or the request shall be deemed to be approved.

(b) Each plan shall maintain a 24-hour multilingual telephone contact number for handling emergencies. Each plan shall ensure that a physician is available 24 hours a day to: coordinate the transfer to a plan provider of a member whose condition is

stabilized; or authorize medically necessary post-stabilization services. Each plan shall have a system to ensure continuity of care and follow-up care for all plan members for whom the plan has denied authorization for emergency services.

(c) A plan may subject all hospital emergency department and emergency physician claims to post-service, prepayment review for post-stabilization services; however claims for medical screening examinations shall not be denied without review. Each plan shall pay emergency services claims at the appropriate level based on the documentation submitted. All properly documented claims for medical screening examinations and emergency services rendered by noncontracted providers shall be paid by the plan within 45 days of receipt of a valid invoice. Each plan shall pay for all claims involving medically necessary services to diagnose and treat nonemergency conditions that the plan has prior authorized.

(d) Each plan shall arrange and make payment for emergency department, emergency physician and emergency transportation services, at the lesser of:

(1) The usual charges made to the general public by the emergency services provider,

(2) The maximum Medi-Cal fee-for-service rate, as specified in sections 51503 and 51509, or

(3) The rate negotiated between the plan and the provider of services for emergency services as defined in section 51056.

(e) For emergency inpatient hospital services, payment shall be made in accordance with the provisions in the contract between the plan and the department.

(f) If disputes arise over claims submitted by providers seeking reimbursement for the provision of emergency services to plan members, the parties shall adhere to the procedures and requirements prescribed in section 53875 for the resolution of such disputes.

(g) In the event the provision of emergency services to plan members is delegated to an entity, such entity, and any further delegatees, shall assume all obligations and responsibilities required under this section. The contractor shall assure compliance with the requirements of this section regardless of the entity providing the emergency services.

53856. Facilities, Service Locations, and Equipment.

Each plan in a designated region shall comply with the requirements contained in section 53230, and shall assure proper sterilization and disinfection of equipment, in accordance with California Occupational Safety and Health Administration (CAL/OSHA) standards, pursuant to California Labor Code, section 6305 or any other applicable federal, state or local standard.

53857. Medical Director.

(a) Each plan in a designated region shall appoint a physician as medical director whose responsibilities shall include, but not be limited to, the following:

(1) Ensuring that medical decisions are:

(A) Rendered by qualified medical personnel.

(B) Are not influenced by fiscal or administrative management considerations.

(2) Ensuring that the medical care provided meets the standards for acceptable medical care.

(3) Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

(4) Developing and implementing medical policy.

(5) Resolving grievances related to medical quality of care.

(6) Actively participating in the functioning of the plan grievance procedures.

(7) Actively participating in the functioning of the plan quality improvement program.

53858. Member Grievance Procedures.

(a) Each plan in a designated region shall establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The grievance system shall include the handling of complaints and shall:

(1) Operate according to the written procedures, which shall be approved in writing by the department prior to use. Amendments shall be approved in writing by the department prior to implementation of the revised procedure.

(2) Be described in information sent to each member within 7 days of the date of enrollment in the plan and annually thereafter, pursuant to sections 53893 and 53894. The description shall include:

(A) An explanation of the plan's system for processing and resolving grievances, and how a member is to use it.

(B) A statement that grievance forms are available in the office of each primary care provider, or in each member services department of the plan, in the case of a plan in which all primary care providers are the exclusive providers of that plan and are contiguously located.

(C) A statement that grievances may be filed in writing or verbally directly with the plan in which the member is enrolled or at any office of the plan's providers.

(D) The local or toll-free telephone number a member may call to obtain information, request grievance forms, and register a verbal grievance.

(E) A written statement explaining the member's right to request a fair hearing, provided pursuant to sections 50951, 51014.1, 51014.2, and 53894.

(F) An explanation of the state's Medi-Cal Managed Care Ombudsman program and the program's voice and TDD telephone numbers.

(b) Each plan shall make local or toll-free telephone service available to members during normal business hours for requesting grievance forms, filing verbal grievances, and requesting information.

(c) Each plan shall provide upon request a grievance form, either directly or by mail if mailing is requested to any member requesting the form.

(d) Each plan shall provide assistance to any member requesting assistance in completing the grievance form.

(e) The member grievance procedures shall at a minimum provide for:

(1) The recording in a grievance log of each grievance received by the plan, either verbally or in writing. The grievance log shall include the following information:

(A) The date and time the grievance is filed with the plan or provider.

(B) The name of the member filing the grievance.

(C) The name of the plan provider or staff person receiving the grievance.

(D) A description of the complaint or problem.

(E) A description of the action taken by the plan or provider to investigate and resolve the grievance.

(F) The proposed resolution by the plan or provider.

(G) The name of the plan provider or staff person responsible for resolving the grievance.

(H) The date of notification of the member of the proposed resolution.

(2) The immediate submittal of all medical quality of care grievances to the medical director for action.

(3) The submittal, at least quarterly, of all member grievances to the plan's quality assurance committee or review and appropriate action. For purposes of this subsection, member grievances shall include but not be limited to those related to access to care, quality of care, and denial of services.

(4) The review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care, quality of care and denial of services, and take appropriate action to remedy any problems identified in such reviews.

(5) The mailing of a written notice of the proposed resolution to the member. Each notice shall include information about the member's right to request a fair hearing pursuant to sections 50951, 51014.1, 51014.2, and 53894.

(6) A system for addressing any cultural or linguistic requirements related to the processing of member grievances prescribed in the contract between the plan and the department.

(7) A procedure for the expedited review and disposition of grievances in the event of a serious or imminent health threat to a member, in accordance with Health and Safety Code section 1368 and 1368.02.

(f) Grievance forms shall be available in the offices of each of the plan's primary care providers, or in each member services department of the plan, in the case of a plan in which all primary care providers are the exclusive providers of that plan and are contiguously located.

(g) Each plan shall adhere to the following requirements and time frames in processing member grievances:

(1) Member grievances shall be resolved within thirty days of the member's submittal of a written grievance or if the grievance is made verbally, it shall be resolved within 30 days of the written record of the grievance.

(2) In the event resolution is not reached within thirty days, the member shall be notified in writing by the plan of the status of the grievance and shall be provided with an estimated completion date of resolution.

(3) Such notice shall include a statement notifying the member they may exercise their right to request a fair hearing in accordance with sections 50951, 51014.1, 51014.2, and 53894.

(h) Each plan shall maintain in its files copies of all grievances, the responses to them, and logs recording them for a period of five years from the date the grievance was filed.

(i) Any member whose grievance is resolved or unresolved shall have the right to request a fair hearing. Submission of a grievance shall not be construed as a waiver of the member's right to request a fair hearing in accordance with sections 50951, 51014.1, 51014.2, and 53894.

53859. Provider Grievances and Complaints.

Each plan shall have a formal process to resolve provider grievances and complaints. A provider of medical services may submit to a plan in a designated region a grievance or complaint concerning the authorization or denial of a service or the processing of a payment or nonpayment of a claim by that plan.

53860. Quality of Care.

(a) Each plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all practitioners providing services on its behalf in all types of settings, including, but not limited to, ambulatory, inpatient and home settings.

(b) Each plan shall implement an effective quality improvement program in accordance with the standards in Title 10, section 1300.70.

(c) In addition to subsection (b), each plan shall implement and maintain a quality improvement program including at a minimum the following elements:

(1) A system of accountability which includes the participation of the plan's governing body, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the plan's medical director, and the inclusion of contracted physicians and other health care providers in the process of quality improvement program development and performance review.

(2) Objective and systematic monitoring and evaluation of the quality and appropriateness of care and services rendered on an ongoing basis, including conducting quality of care studies that address the quality of clinical care as well as the quality of health services delivery.

(3) A utilization management program, including, but not limited to procedures for monitoring under and over-utilization of services, procedures to evaluate medical necessity, prior authorization policies and procedures, and criteria used for approval, referral and denial of services, pursuant to Health and Safety Code, section 1363.5.

(d) The department shall arrange for, at least annually, an external quality of care review of each plan from an entity qualified to conduct such reviews in accordance with Title 42 USC, Section 1396a (30)(C). In addition, as a component of its contract compliance monitoring activities, the department shall conduct annual medical reviews which shall include but not be limited to an appraisal of plan performance in areas such as access to care, continuity of care, quality of care, provision of health education and preventive services, and authorization and denial of services. The department's annual medical reviews shall not duplicate the external quality of care review, except to the extent that such duplication is necessary to verify the plan's compliance with any corrective actions arising out of the external quality of care review. Each plan shall cooperate with and assist both the external quality review organization and the department in the conduct of these reviews.

(e) The department shall issue medical review reports to the plan detailing findings, recommendations, corrective actions and sanctions, as appropriate. Each plan shall comply in full with any corrective action plan issued by the department. Failure to comply may result in the imposition of sanctions as appropriate.

53861. Records.

(a) Each plan in a designated region shall maintain or cause to be maintained all records necessary to verify information and reports required by statute, regulation or contractual obligation for five years from the end of the fiscal year in which the plan contract expires or is terminated. Each plan shall make such records available for inspection or examination to the department, the United States Department of Health and Human Services, the States Department of Justice, or the Comptroller General of the United States or their duly authorized representatives upon request. Records and documents shall include but not be limited to:

(1) Working papers used in the preparation of reports to the department.

(2) Reports to the department, specified in section 53872.

(3) Financial documents.

(4) Medical records.

(5) Quality assurance and improvement records.

(6) Prescription files.

(b) Each plan shall retain or cause to be retained all records pertaining to pending litigation or litigation in progress until the litigation is final.

53862. Reporting.

Each plan in a designated region shall submit to the department:
(a) Annual reports which shall include:

(1) The financial audit required by section 53340. In addition to the annual audited financial statements, the plan shall include the annual report required under section 1300.84.06, Title 10. The plan's annual report shall have a supplemental income statement, prepared in a format consistent with the annual report, reflecting the plan's various Medi-Cal contracts each as a separate line of business by designated region which come included.

(2) An update of the provider listing required in section 53242(b).

(b) Quarterly reports which shall include:

(1) Each plan shall submit to the department, within 45 days after the close of each fiscal quarter, a quarterly financial report in the format prescribed by Title 10, section 1300.84.2. The required financial reports shall have a supplemental income statement, reflecting the plan's various Medi-Cal contracts as separate business operations of the plan by designated region, which combines and correlates to the submitted income statement for the plan.

(c) Other reports which shall be submitted to the department shall include the following:

(1) Utilization and statistical data, including detailed encounter level data, in compliance with the requirements of the contract between the plan and the department.

(2) Pediatric preventive services provided in accordance with the Child Health and Disability Prevention Program reports disclosing services rendered in accordance with Health and Safety Code section 320, et seq., and Title 17, CCR, sections 6840 through 6850 as required by the contract between the plan and the department.

(3) Information requested by the department to conduct medical reviews or contract monitoring in accordance with section 14457, Welfare and Institutions Code.

(4) Financial reports relevant to affiliates as specified in section 53330. These reports will include at a minimum financial statements of affiliates and, if publicly traded, copies of the quarterly Form 10-Q and annual Form 10-K as required by the Securities and Exchange Commission.

(5) Copies of any financial reports submitted to other public or private organizations as specified in section 53324(d).

(6) Upon request, monthly financial statements.

(7) Notification of possible third-party tort liability or estate recovery situations. This information shall be submitted within ten days of discovery.

(8) Reports specified in the contract between the plan and the department.

(9) On a monthly basis, an updated listing of the plan's provider network, by specialty.

(d) Each plan shall submit to public health authorities reports required by state law.

53863. Assumption of Financial Risk.

Each plan shall comply with the assumption of financial risk requirements in section 53251.

53864. Financial Standards/Resources.

(a) Each plan shall demonstrate fiscal soundness and maintain adequate financial resources to carry out its contractual obligations. Such resources shall be determined by the department and shall include, but not necessarily be limited to, the following:

(1) Tangible net equity as defined in Title 10, section 1300.76

(2) Working capital and current ratio of one of the following:

(A) A current ration of at least 1:1, or

(B) Prior demonstration to the department that the contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two years, or

(C) Evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

(3) Demonstration through its history of plan operations that the plan's arrangements for health care are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

(4) Enrollment growth.

(b) Administrative costs incurred by a plan and its affiliates shall comply with the requirements of the Knox-Keene Act as set forth in Title 10, section 1300.78. Plans which compensate their subcontractors on a capitated basis shall comply with title 10, CCR, section 1300.78 regarding administrative costs, considering the combined administrative cost of the plan and its capitated subcontractors for Medi-Cal business.

53865. Financial Performance Guarantee.

(a) Each plan shall provide evidence of and maintain an acceptable financial performance guarantee to the department as specified below.

(b) The department shall approve the form and amount of financial performance guarantee required for each plan contract.

(c) The department may waive the requirement for a financial performance guarantee for a plan which is qualified as an HMO under Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.).

(d) The department shall take possession of the financial performance guarantee sufficient to indemnify the department in the event that the plan defaults on any contractual obligation to the department.

(e) A financial performance guarantee is required, and shall be equal to at least one month's capitation as determined by the department and may be in the form of, but not limited to, one of the following options cited below. The department may extend the time periods for compliance if the department determines that such extension or phase-in will not present a significant financial risk to the State, and if it will not cause the plan to be operated in a manner that may be hazardous to its members.

(1) Guarantee/Performance Bond, or

(2) A guaranteed letter of credit, or

(3) A time certificate of deposit.

A plan electing the time certificate of deposit option may fulfill this requirement by making a deposit with the department, or at the discretion of the department, with any bank authorized to do business in this State and insured by the Federal Deposit Insurance Corporation, or savings and loan association doing business in this State and insured by the Savings Association Insurance Fund. Cash, investment certificates, accounts, or any combination of these shall be assigned to the department, upon those terms as the department may prescribe, until released by the department. The deposit required shall be an allowable asset of the plan in the determination of tangible net equity and all income from the deposit shall be an asset of the plan. A plan that has made a deposit pursuant to this option may withdraw that deposit or any part thereof, after making a substitute deposit of cash, investment certificates, accounts or any combination of these. Any substitute deposit shall be approved by the department before being deposited or substituted.

(4) A trust agreement under a Financial Security Agreement with an approved financial institution.

(5) Withhold from capitation by the department an amount equal to the required amount and retained by the department until completion of the contractual obligations associated with the contract.

53866. Member Billing and Recovery from Other Sources.

Each plan in a designated region may bill plan members or third-party payers for services provided as long as such member billings or recovery efforts from third-parties are conducted in accordance with the requirements of sections 53220 and 53222.

53867. Subcontracts.

Procedures and requirements for the processing and approval of subcontracts for each plan in a designated region shall conform to those specified in section 53250. Subcontracts with federally qualified health centers shall be exempt from the 60-day automatic approval provisions specified in section 53250, unless the department has previously approved, in writing, the plan's proposed reimbursement methodology and rates of payment for federally qualified health centers. Delegation of any obligation or requirement to a subcontractor by a plan shall not release the plan from the responsibility to discharge any obligation or comply with any requirement contained in the contract between the plan and the department.

53868. Reinsurance.

Each plan in a designated region may purchase reinsurance to provide indemnification against unanticipated financial liabilities provided that such coverage is purchased in accordance with the specification and requirements of section 53252.

53869. Capitation Payment, Payment Rate Determination/Redetermination.

(a) In making capitation payments, the department shall adhere to the requirements specified in section 53320. Per capita rates of payment, by the department, for services provided to beneficiaries enrolled in each plan in a designated region shall be payable effective the date a beneficiary's enrollment takes effect. Capitation payments by a plan to a primary care provider or clinic contracting with a plan on a capitation basis shall be payable effective the date of the beneficiary's enrollment where the beneficiary's assignment to or selection of a plan has been confirmed by the plan. However, capitation payments by a plan to a primary care provider for a beneficiary whose assignment to or selection of a primary care provider was not confirmed by the plan on the date of the beneficiary's enrollment, but is later confirmed by the plan, shall be payable no later than 30 days after the beneficiary's enrollment.

(b) The department shall determine capitation payment rates annually by actuarial methods with assistance from an actuary or consulting actuary, except that the department reserves the right to redetermine rates on an actuarial basis or move to a negotiated rate for each rate year.

(c) The rates shall not exceed actuarially equivalent Medi-Cal fee-for-service costs. These costs shall be determined by viewing the total services and requirements, including administration, provided under this Chapter by a local initiative or commercial plan, as though such services and requirements were reimbursable under Chapter 3. For the purposes of this section:

(1) Costs of administration include, but are not limited to:

(A) Salaries, bonuses or benefits paid or incurred with respect to the officers, directors, partners, trustees or other principal management of the plan, minus, to the extent that such persons also are providers of health care services, the minimum reasonable cost of obtaining such health care services from other persons.

(B) Cost of marketing.

(C) Legal and accounting fees and expenses.

(D) Costs associated with the establishment and maintenance of agreements with providers of health care services, excluding the cost of reviewing quality and utilization of such services and cost of reviewing utilization of health care services on a referral basis.

(E) Premium on required fidelity and surety bonds and any insurance maintained pursuant to Health and Safety Code, section 1377, and any insurance or other expense incurred for the purpose of complying with Health and Safety Code, section 1375.1.

(F) Costs of preparing reports required by this Chapter.

(G) Costs of maintaining facilities for administrative services.

(2) Costs of administration shall not include:

(A) Bad debt write-off.

(B) Donations.

(C) Out-of-state and out-of country travel.

(D) Expenditures for commercial market development.

(E) Stock losses.

(F) Good will.

(G) Malpractice insurance.

(d) Capitation rates shall be effective for one year beginning the first day of October each year. In the event that payment of the new rates is delayed beyond the first day of October, continued payment of the rate in effect shall be interim payment only. Final payment shall be:

(1) Adjusted by any increase or decrease to the level of the new rates.

(2) Effective as of the first day of October.

(e) Notwithstanding subsection (d), payment of the new annual rates shall commence no later than December 1, provided that a contract amendment providing for the new annual rates has been prior approved by the United States Department of Health and Human Services, and signed by the department and the plan, but has not yet received the approval of all required control agencies and departments.

(f) Contract amendments providing for the new annual rates shall provide that:

(1) The plan stipulates to a confession of judgment, for any amounts received in excess of the final approved rate, by accepting payment of the new annual rates prior to final approval.

(g) Any underpayment by the State, if the final approved rates differ from the rates set forth in an amendment providing for new annual rates, shall be paid by the department to the plan within 30 days after final approval of such rate amendment.

(h) Any overpayment by the department shall be recovered by withhold of the amount due from the plan's next capitation payment, not to exceed 25 percent of the capitation payment. If the overpayment is more than 25 percent, amounts up to 25 percent shall be withheld from each successive capitation payment until such deficiencies are recovered by the department. Upon termination the department may recover all amounts outstanding from the last capitation payment.

(i) The contract between the department and a local initiative or commercial plan shall include:

(1) The monthly capitation rates.

(2) A description of the actuarial method, assumptions, cost information and utilization rates used in determining the rates.

(j) In redetermining capitation rates, the department shall follow to the requirements specified in section 53322.

53870. Affiliated Organizations and Persons.

(a) Every affiliate of a plan in each designated region shall:

(1) Furnish, upon request, to the plan and to the department financial reports relevant to the disposition of funds paid to the affiliate by the plan. Reports shall be prepared according to generally accepted accounting principals and shall provide all financial data required by the plan to fulfill its obligations to the department for financial reporting.

(2) Make all books and records, which are pertinent to plan contracts with the department available for inspection by the department and the United States Department of Health and Human Services. These books and records shall be retained for at least five years from the close of each fiscal year in which the contract is in effect.

53871. Financial Audit.

Each plan in a designated region shall have an annual audit performed by an independent certified public accountant in accordance with the provisions of section 53340, except that this audit shall be received by the department no later than 120 days after the close of the plan's fiscal year, or 180 days for public entities whose audits are conducted by a county grand jury.

53872. Civil Penalties.

(a) The Director may, except as provided in section 53873, impose one or more of the civil penalties specified in (b) upon a plan which fails to comply with the provisions of Article 2.7 of Chapter 7, Part 3, of Division 9 of the Welfare and Institutions Code, the provisions of this Chapter, or the terms of the plan contract.

(b) Civil penalties imposed by the Director shall be in the amounts specified below with respect to violation of any provision of:

(1) Article 2, excluding section 53862.

(A) First violation: $1,000.

(B) Second violation: $5,000.

(C) Third and each subsequent violation: $10,000.

(2) Article 3.

(A) First violation: $5,000.

(B) Second and each subsequent violation: $10,000.

(3) Section 53862.

(A) First violation: $1,000, plus $500 per day for each day that the item to be submitted is late, not to exceed $10,000 total for each violation.

(B) Second and each subsequent violation: $5,000, plus $500 per day for each day that the item to be submitted is late, not to exceed $10,000 total for each violation.

(4) The contract, which is not specifically governed by regulation in this Chapter.

(A) First violation: $5,000.

(B) Second and each subsequent violation: $10,000.

(5) Article 2.7, Chapter 7, Part 3, Division 9 of the Welfare and Institutions Code, which is not specifically addressed by regulations in this Chapter.

(A) First violation: $5,000.

(B) Second and each subsequent violation: $10,000.

(c) The counting of violations for the purposes of this section shall:
(1) Be done without regard to contract term.

(2) Commence with violations occurring on or after the effective date of this section.

(d) Imposition of penalties, under the provisions of subsection (a) shall follow administrative proceedings held in accordance with the provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2, Government Code.

(e) The department shall issue a letter of noncompliance to a plan found by the administrative proceedings addressed in subsection (d) to be in violation of any provision of law, regulation or the contract. The letter of noncompliance shall include the violation, sanctions to be imposed and corrective action to be taken within stated time limits. Failure to comply with corrective actions within the time limits given shall be deemed to be subsequent violation for the purposes of subsection (c).

53873. Contract Termination.

In terminating a contract with a plan in a designated region, the department shall adhere to the procedures and requirements prescribed in section 53352, except for subsection (d) and (e).

53874. Conflict of Interest.

In entering into contracts or subcontracts, each plan in a designated region shall comply with the prohibitions against contracting relating to conflict of interest set forth in section 53600 except as otherwise provided in Welfare and Institutions Code, sections 14087.31(k), 14087.35(p)(1), 14087.36(v)(1), 14087.38(h), and 14087.969.

53875. Emergency Services Claims Disputes.

In resolving disputes over claims for reimbursement for emergency services provided to plan members by nonplan providers, the involved parties and the department shall adhere to the procedures and requirements set forth in Article 7 of Chapter 4, commencing with section 53620 except subsection (e) of section 53676.

53876. Cultural and Linguistic Requirements.

(a) Each plan in a designated region shall implement and adhere to the cultural and linguistic services requirements of the contract between the plan and the department. The contract at a minimum shall include requirements for:

(1) Interpreters.

(2) Translated signage.

(3) Translated written materials.

(4) Referrals to culturally and linguistically appropriate community services programs.

(b) In consultation with representatives from contracting plans and community-based diverse cultural and linguistic groups, the department shall develop, and update as appropriate, a set of comprehensive cultural and linguistic requirements which shall be incorporated into the contract between the department and each plan in a designated region.

(c) The plan shall establish and maintain a community advisory committee, and meet periodically with the committee concerning the development and implementation of its cultural and linguistic accessibility standards and procedures.

53880. Marketing.

(a) Each plan in a designated region shall limit its marketing activities to printed, illustrated, or video taped materials, and media advertising. Plans may participate in an organized community or neighborhood health fair in a public place for marketing purposes.

(1) Printed and illustrated materials may be available to members or prospective members, as follows:

(A) By mail. Printing, postage, and any related costs of material mailed to prospective members shall be paid by the plan. The department shall conduct all mailings to ensure the confidentiality of Medi-Cal beneficiaries is protected.

(B) By posting materials in public places.

(C) At health care options presentations, which shall be conducted pursuant to section 53886.

(b) Prior to engaging in marketing activities, each plan shall submit a marketing plan which shall be approved in writing by the department prior to its implementation.

(c) All marketing materials, including but not limited to, all printed materials, illustrated materials, video taped and media scripts shall be approved in writing by the department prior to distribution to members or prospective members.

(d) No representative of a plan shall contact prospective members for the purposes of marketing, except in cases where the contact is initiated by the prospective member, unless that contact is approved in writing by and coordinated through the department, pursuant to (a)(1)(A), above. However, physicians, mid-level practitioners, nurses, or office staff may discuss plan membership with their patients. Each plan shall be responsible for informing all network providers they may not distribute unauthorized or unapproved material to Medi-Cal beneficiaries.

(e) All marketing materials, presentations and displays shall conform to the cultural and linguistic requirements prescribed in the contract between the plan and the department.

(f) A plan shall not engage in door-to-door marketing for the purpose of enrolling members, or any other purpose.

53881. Marketing and Member Materials.

(a) The Evidence of Coverage, disclosure form, and any marketing brochure developed by or for a plan in a designated region and distributed to prospective members shall meet the requirements contained in Health and Safety Code, section 1363.1, and Title 10, section 1300.63(a), as to print size, readability, and understandability of text.

(b) Evidence of coverage and disclosure forms or member services guides distributed to eligible beneficiaries by a plan shall fully disclose the availability of and restrictions upon the services provided by the plan, and any exclusions from coverage. These materials shall, at a minimum, specify:

(1) The scope, access to, and availability of services, including service site locations and telephone numbers, and the service area authorized in that plan's contract.

(2) A description of the membership identification card issued by the plan, if applicable, and an explanation as to its use in authorizing or assisting members to obtain services.

(3) That members shall obtain all Medi-Cal health care services covered by the plan's contract through the plan's providers.

(4) That medical services required in an emergency may be obtained from specified plan providers or from non-plan providers, if necessary.

(5) The disenrollment process, and an explanation that disenrollment is possible only under the conditions specified in section 53891 and is effective only after the disenrollment transaction is completed by the Health Care Options Program as specified in section 53889.

(6) The plan's grievance process, including instructions on how to use it.

(7) That members have the right to a fair hearing, including instructions on how to request one.

(8) The interpreter, linguistic, and cultural services available through plan personnel.

(9) Any transportation services to service sites that are available through the plan or under the Medi-Cal program. This shall include a description of both medical and non-medical transportation services, and the conditions under which non-medical transportation is available to members.

(10) Information on the availability of and procedures for obtaining services at Federally Qualified Health Centers and Indian Health Service facilities.

(11) Information on the member's right to seek family planning services from any qualified provider eligible to provide family planning services under the Medi-Cal program, including providers outside the plan's provider network, how to access these services, and a description of the limitations on the services that beneficiaries may seek outside the plan.

(12) Information on the availability and procedures for obtaining nurse midwife and nurse practitioner services.

(13) Information concerning the availability of services covered under the State's California Children Services (CCS) program from providers outside the plan's provider network and how to access these services.

(14) An explanation of the disenrollment process for members qualifying for expedited disenrollment as specified in section 53889.

(15) Information on how to obtain minor consent services through the plan, and an explanation of those services.

(16) An explanation of an American Indian beneficiary's right to not enroll in a plan, not be restricted in their right to access Indian Health Facilities by a plan, and their right to disenroll from a plan without cause.

(17) The information specified in section 53895(b).

53882. Member Enrollment.

(a) Enrollment in a plan in a designated region shall be mandatory for those eligible beneficiaries specified in section 53845(a), and voluntary for those specified in section 53845(b).

(b) Enrollment shall be limited to eligible beneficiaries who reside within the designated region, except as provided in section 53845(d).

(c) The department or the Health Care Options Program shall mail an enrollment form and plan information to each eligible beneficiary described in section 53845(a) who does not attend a health care options presentation as described in section 53886. The mailing shall include health care options information and instructions to enroll in a plan within thirty days of the postmark date on the mailing envelope. At a minimum, the mailing shall include instructions on how to enroll, how to request an exemption from mandatory enrollment for medical or nonmedical reasons, and how to request a medical exemption certification form.

(d) Each eligible beneficiary described in section 53845(a) shall select a plan within thirty days of receipt of an enrollment form unless requesting an exemption to plan enrollment is submitted to the Health Care Options Program within 30 days of receipt as prescribed in section 53887(b), or within thirty days of the postmark date of the health care options information if mailed, with instructions from the department or the Health Care Options Program to select a plan.

(1) In the event an eligible beneficiary described in section 53845(a) does not select a plan within thirty days, the Health Care Options Program shall assign the eligible beneficiary to a plan, in accordance with section 53883.

(2) For purposes of selecting a plan:

(A) In the case of a family group, eligible beneficiary means the individual or entity with legal authority to make a choice on behalf of dependent family members.

(e) An eligible beneficiary shall not be enrolled in more than one plan at any one time.

(f) The Health Care Options Program shall process all enrollments.

(g) An eligible beneficiary is enrolled upon completion of all of the following events:

(1) Either of the following enrollment activities:

(A) The voluntary signing and dating by the eligible beneficiary of an enrollment form, except as provided under section 53845(c), and departmental validation of the beneficiary's enrollment form; or

(B) The assignment, as specified in section 53883, of an eligible beneficiary to a plan.

(2) Departmental verification of the beneficiary's Medi-Cal eligibility.

(3) Addition of the beneficiary's name to the approved list of members, which is effective the first day of any given month and which is furnished monthly to the plan by the department.

53883. Assignment of Eligible Beneficiaries to Plans.

(a) The Health Care Options Program shall assign an eligible beneficiary described in section 53845(a) to a plan within a designated region, from which to receive health care services, in the following situations:

(1) In the event the eligible beneficiary does not select a plan within thirty days of receiving an enrollment form pursuant to section 53882(d).

(2) In the event a member requests and is granted disenrollment from either plan within that region, pursuant to section 53891, but does not enroll in the competing plan, unless that member was granted approval by the department or its designee to receive health care services through the fee-for-service Medi-Cal program, pursuant to section 53887.

(3) In the event the competing plan is at capacity, the fee-for-service Medi-Cal option shall be made available.

(b) In carrying out (a), the Health Care Options Program shall comply with the assignment requirements contained in section 53884.

53884. Assignment System.

(a) The Health Care Options Program shall implement a system within each designated region approved by the department to assign an eligible beneficiary described in section 53845(a), to a plan, in the event the beneficiary does not select a plan pursuant to section 53882(d).

(b) In assigning an eligible beneficiary to a plan, the Health Care Options Program's system shall, at a minimum, consider the following:

(1) Zip code of eligible beneficiary matched to zip codes served by the plan in accordance with the provisions of section 50185.5(f).

(2) Enrollment capacity and availability of the plan.

(3) Plan's ability to render linguistically appropriate services and the eligible beneficiary's need for those services, if made known to the Health Care Options Program.

(4) Assignment of family members to the same plan to the extent possible.

(5)(A) Assignments between plans shall be distributed in accordance with an agreement, approved by the Department, between a local initiative and a commercial plan in a designated region; or

(B) in the absence of an approved agreement, the Department shall determine how assignments shall be distributed in a designated region.

(6) In approving an agreement between a local initiative and a commercial plan, or when the Department determines how assignments shall be distributed, the Department may consider the following factors:

1. The potential for a high level of informed beneficiary choice of plans and providers.

2. The potential for the local initiative to achieve an enrollment level that reasonably allows it to spread financial risk and a reasonable opportunity for it to attain financial viability.

3. Maintaining the level of disproportionate share hospital days and safety net providers in the region so that neither is adversely affected by the mandatory enrollment of Medi-Cal beneficiaries in managed care, when compared to Medi-Cal program levels prior to implementing the two-plan model in the region.

4. The need to assure that a commercial plan is not precluded from receiving default assignments, other than during a limited time period immediately preceding and following local initiative start-up.

5. The ability of the department's enrollment contractor to accurately and timely perform the selected assignment distribution methodology.

53885. Travel Distance Standards.

(a) Each plan shall ensure that primary health care services provided through the plan are no more than 30 minutes travel time or ten (10) miles travel distance from each member's place of residence, unless the department has approved an alternative time and distance standard.

(b) An eligible beneficiary may voluntarily choose to receive services from a plan service site with a travel time or distance that exceeds the requirements in subsection (a).

53886. Health Care Options Presentation.

(a) The Health Care Options Program shall provide, in each designated region, a presentation of plan options to each new and continuing eligible beneficiary who meets the mandatory enrollment criteria specified in section 53845 and to any eligible beneficiary who meets the voluntary enrollment criteria specified in section 53845 and requests a presentation. For non-English or limited English speaking beneficiaries, presentations shall be made in the beneficiary's preferred language. Reasonable accommodations shall be made for persons who are blind, deaf or hearing impaired. At the department's discretion, the presentation may be in person or by mail. The department shall ensure that any eligible beneficiary requesting a face-to-face presentation is provided the opportunity to have such presentation at the earliest possible time and in the most convenient location possible, or is given the opportunity to speak with a telephone representative provided by the Health Care Options Program for assistance in making a plan selection.

(b) The health care options presentation shall include, at a minimum, the following information:

(1) The names of each plan.

(2) Each plan's service area.

(3) The name, address, telephone number, and specialty, if any, of each primary and specialty care provider or clinic participating in each plan. Providers participating in each plan will be listed alphabetically by last name and grouped by geographic area.

(4) The process for selecting or changing a primary care provider and an explanation that beneficiaries have the right to select a primary care clinic as their primary care provider and to change their primary care provider at any time.

(5) Services covered by each plan.

(6) Procedures for accessing and receiving health care services from each plan.

(7) Hospitals used by each plan.

(8) Any features or additional services, including cultural and linguistic services, provided by each plan, pursuant to the contract.

(9) An explanation that a beneficary eligible for voluntary enrollment may submit a request for disenrollment from the plan at any time, in accordance with the provisions of section 53891.

(c) For eligible beneficiaries for whom plan enrollment is mandatory, the following additional information shall be provided:

(1) An explanation that an exemption from plan enrollment exists for American Indians, members of American Indian households, and others eligible to receive health care services through an Indian Health Service facility, as specified in section 53887(a)(1).

(2) An explanation that an exemption from plan enrollment may be obtained for individuals with complex medical conditions, as specified in section 53887(a)(2), and how to request such an exemption.

(3) An explanation that if beneficiaries do not select a plan within 30 days, they will be assigned to a plan.

(4) An explanation that beneficiaries have the right to disenroll from a plan and reenroll in the competing plan at any time, in accordance with section 53891.

(d) The Health Care Options Program shall provide assistance to eligible beneficiaries in enrollment/disenrollment, as needed.

(e) Prior to either requesting enrollment by signing a written request or being assigned to a plan in a designated region in accordance with section 53883, each eligible beneficiary shall be informed in writing by the department or the Health Care Options Program of at least the following:

(1) There will be a 15 to 45 day processing time between the date of application or assignment and the effective date of enrollment in a plan.

(2) Until plan enrollment is effective, the beneficiary may receive Medi-Cal covered health care services from any Medi-Cal provider licensed to provide the services.

(3) An explanation of the process for requesting exemption from plan enrollment for the reasons specified in section 53887.

(f) In the event disenrollment from a plan is restricted pursuant to section 53891(b) during the second through sixth month of enrollment, the Health Care Options Program shall inform beneficiaries of the conditions of disenrollment.

53887. Exemption from Plan Enrollment.

(a) An eligible beneficiary meeting the criteria specified in section 53845(a), who satisfies the requirements in (1) or (2) below, may request fee-for-service Medi-Cal for up to 12 months as an alternative to plan enrollment by submitting a request for exemption from plan enrollment to the Health Care Options Program as specified in (b) below.

(1) An eligible beneficiary who is an American Indian as specified in section 55100(i), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) An eligible beneficiary who is receiving fee-for-service Medi-Cal treatment or services for a complex medical condition, from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of either plan in the eligible beneficiary's county of residence, may request a medical exemption to continue fee-for-service Medi-Cal for purposes of continuity of care.

(A) For purposes of this section, conditions meeting the criteria for a complex medical condition include, and are similar to, the following:

1. An eligible beneficiary is pregnant.

2. An eligible beneficiary is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.

3. An eligible beneficiary is receiving chronic renal dialysis treatment.

4. An eligible beneficiary has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).

5. An eligible beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.

6. An eligible beneficiary has been approved for a major surgical procedure by the Medi-Cal fee-for-service program and is awaiting surgery or is immediately post-operative.

7. An eligible beneficiary has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in 1. through 6. above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted.

8. An eligible beneficiary is enrolled in a Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in a sub-acute care facility, an acute care hospital, an intermediate care facility or a skilled nursing facility.

9. An eligible beneficiary is participating in a pilot project organized and operated pursuant to sections 14087.3, 14094.3, or 14490 of the Welfare and Institutions Code.

(B) A request for exemption from plan enrollment based on complex medical conditions shall not be approved for an eligible beneficiary who has:

1. Been a member of either plan on a combined basis for more than 90 calendar days,

2. A current Medi-Cal provider who is contracting with either plan, or

3. Begun or was scheduled to begin treatment after the date of plan enrollment.

(3) Except for pregnancy, any eligible beneficiary granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without deleterious medical effects, as determined by a beneficiary's treating physician in the Medi-Cal fee-for-service program, up to 12 months from the date the medical exemption is first approved by the Health Care Options Program. A beneficiary granted a medical exemption due to pregnancy may remain with the fee-for-service Medi-Cal provider through delivery and the end of the month in which 90 days post-partum occurs.

(4) Any extension to the 12-month medical exemption time limit shall be requested through the Health Care Options Program no earlier than 11 months after the starting date of the exemption currently in effect. The Health Care Options Program will notify the beneficiary 45 days before the expiration of an approved medical exemption and will inform the beneficiary how to request an extension. An extension to the medical exemption shall be approved if the eligible beneficiary continues to meet the requirements of subsection (a)(2).

(b) Exemption from plan enrollment or extension of an approved exemption due to a complex medical condition, as specified in (a)(2)(A), shall be requested on the "Request for Medical Exemption from Plan Enrollment" form (HCO Form 7101, June 2000), hereby incorporated by reference, which is available from the Health Care Options Program. Exemption from plan enrollment or extension of an approved exemption due to a beneficiary's enrollment in a Medi-Cal waiver program, as specified in (a)(2)(A)8, or a beneficiary's acceptance for care at an Indian Health Service facility, as specified in (a)(1), shall be requested on the "Request for Non-Medical Exemption from Plan Enrollment" form (HCO Form 7102, October 2000), hereby incorporated by reference, which is available from the Health Care Options Program. The completed request for exemption shall be submitted to the Health Care Options Program by the Medi-Cal fee-for-service provider or the Indian Health Service facility treating the beneficiary and shall be submitted by mail or facsimile. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(c) The Health Care Options Program, as authorized by the department, shall approve each request for exemption from plan enrollment that meets the requirements of this section. At any time, the department may, at its discretion, verify the complexity, validity, and status of the medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with a plan. The Health Care Options Program, as authorized by the department, or the department may deny a request for exemption from plan enrollment or revoke an approved request for exemption if a provider fails to fully cooperate with this verification.

(d) Approval of requests for exemption from plan enrollment is subject to the same processing times and effective dates specified in section 53889 for the processing of enrollment and disenrollment requests.

(e) The Health Care Options Program, as authorized by the department, or the department may revoke an approved request for exemption from plan enrollment at any time if the department determines that the approval was based on false or misleading information, the medical condition was not complex, treatment has been completed, or the requesting provider is not or has not been providing services to the beneficiary. The department shall provide written notice to the beneficiary that the approved request for exemption from plan enrollment has been revoked and shall advise the beneficiary that they must enroll in a Medi-Cal plan and how that enrollment will occur, as specified in section 53882. The revocation of an approved request for exemption from plan enrollment shall not otherwise affect an eligible beneficiary's eligibility or ability to receive covered services as a plan member.

53888. Enrollment/Disenrollment Form.

(a) The Health Care Options Program shall make the enrollment/disenrollment form available in the Health Care Options information packets mailed to mandatory eligible beneficiaries, at the Health Care Options presentations, and at department-approved Health Care Options Program sites. The Health Care Options Program shall mail the enrollment/disenrollment form to a beneficiary within three working days of receiving a telephone or written request for a form.

(b) Plans shall make the enrollment/disenrollment form available at the member services departments and shall mail the form to a beneficiary within three working days of receiving a telephone or written request for a form.

53889. Enrollment/Disenrollment Processing.

(a) An eligible beneficiary shall submit an enrollment or disenrollment request on an original, signed enrollment/disenrollment form to the Health Care Options Program by mail or in person at department-approved Health Care Options Program sites. Expedited disenrollment requests may also be submitted by facsimile. An eligible beneficiary also may request expedited disenrollment over the telephone from the Health Care Options Program.

(b) An eligible beneficiary shall provide the following information on the enrollment/disenrollment form when requesting enrollment or disenrollment: first and last name of the beneficiary; sex; date of birth; Social Security Number; Medi-Cal number; complete mailing address; telephone number, if available; plan choice, if requesting enrollment; name and address of doctor or clinic beneficiary is choosing as primary care provider; language of the beneficiary; and the reason for disenrolling, if requesting disenrollment. If the beneficiary is requesting enrollment or disenrollment for any other eligible family member, the same information shall be provided for the other eligible beneficiaries on the same form where indicated. The beneficiary or authorized representative, as specified in (h), shall sign and date the enrollment/disenrollment form.

(c) The Health Care Options Program shall assist with, accept and process enrollment and disenrollment requests regardless of the beneficiary's race, creed, color, religion, age, sex, national origin, ancestry, marital status, sexual orientation, physical or mental disability, or pre-existing medical conditions.

(d) The Health Care Options Program shall ensure that beneficiaries are informed of their right to request a fair hearing in accordance with sections 50951, 51014.1, 51014.2, and 53894.

(e) The Health Care Options Program shall accept and process all completed enrollment and disenrollment requests, including expedited disenrollment requests, from eligible beneficiaries within two working days of receipt if such requests meet the conditions for plan disenrollment specified in section 53891.

(f) Approval of enrollment and disenrollment requests is conditioned upon receipt of a fully completed enrollment/disenrollment form and all required supporting documentation.

(g) The Health Care Option Program shall notify beneficiaries in writing of the approval or disapproval of enrollment and disenrollment requests, including expedited disenrollment requests, within seven working days of receipt of the request. This notice shall include the effective date of the enrollment and/or disenrollment, as specified in (h) below.

(h) Enrollment and disenrollment requests may be submitted by the beneficiary or other authorized individuals listed in (1) through (7) below:

(1) Persons with legal authority to act on the beneficiary's behalf. Such persons include, but are not limited to, parents, legal guardians, publicly appointed guardians, and other legally designated representatives.

(2) Department staff responsible for the administration of the Two-Plan Model Program and Health Care Options Program staff.

(3) County staff, including but not limited to, social workers, probation officers, caseworkers, and other local government personnel responsible for supervision or case management of the beneficiary.

(4) Foster parents or parents adopting a child in the Adoption Assistance Program.

(5) Medi-Cal managed care Two-Plan Model Program contractors.

(6) Case managers, physicians or medical staff of the Medi-Cal home and community-based services waiver programs.

(7) Care coordinators at Regional Centers for the Developmentally Disabled.

(i) The effective date of enrollment or disenrollment is determined as follows:

(1) Enrollment requests and non-expedited disenrollment requests processed before the monthly update to the Medi-Cal Eligibility Data System shall be effective on the first day of the month following the month in which the request is processed.

(2) Enrollment requests and non-expedited disenrollment requests processed after the monthly update to the Medi-Cal Eligibility Data System shall be effective on the first day of the second month following the month in which the request is processed.

(3) Expedited disenrollment requests shall be effective on the first day of the month in which the request is processed, whether submitted before or after the monthly update to the Medi-Cal Eligibility Data System.

(j) The Health Care Options Program shall process all completed disenrollment requests meeting the requirements of section 53891 as expedited disenrollments if they also meet the criteria in (1) and (2) below. Approved expedited disenrollments are effective as specified in (i)(3) in this section.

(1) The beneficiary has not used services for which the plan is contractually obligated to pay during the month for which disenrollment is requested, and

(2) Disenrollment is requested for one of the following reasons, and all required supporting documentation is provided:

(A) The beneficiary is an American Indian, a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from the Indian Health Service facility for care on a fee-for-service basis.

(B) The beneficiary is receiving services under the Foster Care or Adoption Assistance Program or has been placed in the care of Child Protective Services. The disenrollment request must be submitted by the authorized foster parent, the authorized adoptive parent, or the licensed agency providing protective services.

(C) The beneficiary has a complex medical condition, specified in section 53887(a)(2)(A), and the disenrollment request is submitted with verification of the medical condition, treatment plan, and duration of treatment by the Medi-Cal fee-for-service physician.

(D) The beneficiary is enrolled in a Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in a sub-acute care facility, acute care hospital, intermediate care facility or skilled nursing facility. Verification of participation in the waiver program must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative as specified in (h).

(E) The beneficiary is participating in a pilot project organized and operated pursuant to sections 14087.3, 14094.3, or 14490 of the Welfare and Institutions Code. Verification of participation in the pilot program must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative as specified in (h).

(F) The Health Care Options Program incorrectly enrolled or assigned the eligible beneficiary to a plan not chosen by the beneficiary, as determined by the Health Care Options Program, the beneficiary or the plan and verified by the Health Care Options Program. An explanation of the incorrect enrollment or assignment must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative as specified in (h).

(G) The beneficiary submitted a non-expedited disenrollment request that meets the requirements for disenrollment or a request for exemption from plan enrollment based upon a qualifying complex medical condition that was not timely processed by the Health Care Options Program. An explanation of the lack of timely processing must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative as specified in (h).

(H) The beneficiary has moved or been placed outside of the plan service area and has notified his or her caseworker of the new address. If the beneficiary's new address is not yet shown in the Medi-Cal Eligibility Data System, the beneficiary is responsible for requesting that the caseworker provide verification of the new address to the Health Care Options Program by telephone, facsimile, or in writing.

(I) The beneficiary or plan has experienced an irreconcilable breakdown in the patient-physician relationship, has used the plan's problem resolution process, and the department has approved the disenrollment. Documentation of the irreconcilable breakdown in the patient-physician relationship, including the use of the plan's problem resolution process, must be submitted with the disenrollment request by the beneficiary, the beneficiary's authorized representative as specified in (h), or the plan. Use of the plan's problem resolution process shall not be required in situations where a beneficiary's behavior presents physical risk to plan staff, a provider, or staff at a provider site, and the plan or provider has filed a police report regarding the physical risk.

(J) The beneficiary was enrolled in the plan due to incorrect information provided by the Health Care Options Program or due to prohibited marketing practices by the plan, as determined by the Health Care Options Program, the beneficiary or the plan and verified by the Health Care Options Program. Explanation of the incorrect information or the prohibited marketing practices must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative, as specified in (h).

(K) The beneficiary requires nursing facility services, other than members requesting hospice services, has been admitted to a long-term care facility and will remain in long-term care for more than two consecutive months. The name of the long-term care facility and the date of admission must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative as specified in (h).

(L) The beneficiary is deceased, and the death is not yet reflected in the Medi-Cal Eligibility Data System. A copy of the death certificate must be submitted with the

disenrollment request by the beneficiary's authorized representative as specified in (h).

(k) The Health Care Options Program shall notify the plan of enrollment and disenrollment on a weekly basis. However, enrollment and disenrollment is effective only when confirmed by the department's eligibility information contained in the Medi-Cal Eligibility Data System update that is provided monthly to plans.

53890. Assignment of Primary Care Physician.

(a) Each plan in a designated region shall have a mechanism in place and approved in writing by the department to ensure that each member is assigned to a primary care physician, by either:

(1) Allowing each member to select a primary care physician from the plan's network of affiliated physicians, if the member chooses to do so; or

(2) Assigning a primary care physician to each member within forty days from the effective date of enrollment, if the member does not select one within the first thirty days of the effective date of enrollment in the plan. This assignment shall meet the conditions of both:

(A) The member shall be assigned to a primary care physician within the maximum travel distances specified in section 53885.

(B) The member shall be assigned to a primary care physician who is or has office staff who are linguistically and culturally competent to communicate with the member or have the ability to interpret in the provision of health care services and related activities during the member's office visits or contacts, if the language or cultural needs of the member are known to the plan.

(b) The plan shall provide the member written notice of their assignment to a primary care physician within 10 days of their assignment, and informing the member of their right to choose another primary care physician from the plan's list of approved primary care physicians.

(c) Any member dissatisfied with the primary care physician selected or assigned shall be allowed to select or be assigned to another primary care physician. Each plan shall assist its members in changing primary care physicians if that change is requested by the member. Any request by a member to change primary care physicians shall be processed by the plan within 30 days of the date the request is received by the plan.

(d) Any plan physician dissatisfied with the physician/patient relationship with any member may request that the member select or be assigned to another primary care provider.

53890.5. Assignment of a Primary Care Provider.

(a) If the plan utilizes nonphysician practitioners, members may select, be assigned to, or change such providers in accordance with the provisions of section 53890.

(b) In all cases where a nonphysician practitioner is a member's primary care provider, the plan shall ensure that a primary care physician is responsible for the overall coordination of the member's health care, consistent with applicable state and federal laws and regulations.

53891. Disenrollment of Members.

(a) The Health Care Options Program shall disenroll any member from a plan when one of the following conditions is met:

(1) A member's eligibility for enrollment as a Medi-Cal beneficiary is terminated.

(2) The Health Care Options Program incorrectly enrolled or assigned a member to a plan not of his/her choosing, as indicated on the enrollment request form completed by beneficiary.

(3) A member was enrolled in the plan due to incorrect information provided by the Health Care Options Program or due to prohibited marketing practices by the plan as specified in sections 53880 or 53881.

(4) A member's request for disenrollment is due to plan merger or reorganization.

(5) There is a change of a member's place of residence to outside the plan's service area.

(6) A member requests the disenrollment for any reason and the request is not made during any restricted disenrollment period for that member.

(7) The member or the plan requests disenrollment for good cause, as specified below, when the request is made during any restricted disenrollment period for the member. For the purposes of this subsection, good cause for disenrollment means one of the following:

(A) The member requires Medi-Cal services that are excluded under the terms of the plan's contract and which can be obtained only if the member disenrolls from the plan.

(B) The plan requests disenrollment because the member uses or permits to be used fraudulently the member's Medi-Cal coverage under the plan, as defined in Welfare and Institutions Code section 14043.1(d). Fraudulent use includes allowing others to use the member's plan membership card to receive services from the plan or to submit claims for services which were not provided to the member.

(C) The plan or member requests the disenrollment because of an irreconcilable breakdown in the physician-patient relationship, specified in section 53889(j)(2)(I).

(D) The member or plan requests the disenrollment for any other reasons determined by the department to constitute good cause.

(8) The member requests disenrollment for one of the reasons specified for exemption from plan enrollment in section 53887 and meets the criteria specified in that section.

(9) The member meets the criteria for expedited disenrollment in accordance with section 53889(j).

(10) The member becomes enrolled in one of the following forms of other health coverage, except when dual enrollment is permitted as specified in Section 53845(f):

(A) Medicare HMO

(B) CHAMPUS Prime HMO

(C) Kaiser HMO

(D) Any other HMO/Prepaid Health Plan in which the enrollee is limited to a prescribed panel of providers for comprehensive service.

(b) The department may restrict disenrollment from a plan during the second through sixth month of a member's initial enrollment in the plan when all of the following apply:

(1) Both plans in a designated area are operational.

(2) Both plans have requested restricted disenrollment.

(3) The department's federal waiver or State Plan amendment authorizing operation of the Two-Plan Model Program authorizes restricted disenrollment.

(c) Each disenrollment request shall be accompanied by an enrollment request for enrollment in the competing plan unless the member has moved out of the plan's service

area, meets the criteria in section 53887 for exemption from plan enrollment, will be incarcerated for more than one month, or is eligible for voluntary enrollment. Any member who does not select the competing plan shall be assigned, in accordance with section 53883. If the competing plan is at enrollment capacity, fee-for-service Medi-Cal shall be made available to the eligible beneficiary.

(d) Disenrollment requests shall be processed in accordance with the provisions of section 53889.

53892. Problem Resolution Process for Members.

(a) Any member of a plan may request assistance by telephone, facsimile, in writing, or in person from the Health Care Options Program in resolving problems associated with mandatory or voluntary enrollment or disenrollment in the Two-Plan Model Program or assignment to a plan.

(b) If the Health Care Options Program is not able to resolve the problem through the procedures for processing enrollment and disenrollment specified in section 53889, then the Health Care Options Program shall first direct the beneficiary to the plan in which the beneficiary is a member, unless the beneficiary has already been to the plan to attempt to resolve problems resulting from plan enrollment or disenrollment. If the beneficiary wishes to disenroll from the plan, the Health Care Options Program shall advise the beneficiary of the options to:

(1) Be referred to the plan's problem resolution process.

(2) Be referred to the department's Medi-Cal Managed Care Ombudsman and the Department of Managed Health Care's Office of the Patient Advocate.

(c) If the beneficiary is referred to a plan's problem resolution process, the Ombudsman or the Department of Managed Health Care's Office of the Patient Advocate, the Health Care Options Program shall provide an estimated time frame within which the member shall be contacted by the plan, the Ombudsman or the Department of Managed Health Care's Office of the Patient Advocate.

(d) If the beneficiary still wishes to disenroll, the Health Care Options Program shall process the disenrollment request as specified in sections 53889 and 53891.

(e) If the member and the plan have been unsuccessful in resolving the problem to the member's satisfaction, but the member does not want to disenroll, the plan shall forward the problem to the department's Ombudsman by the next working day following the day on which the member indicates he/she does not want to disenroll.

(1) The plan shall tell the beneficiary when the beneficiary may expect to be contacted by the Ombudsman.

(f) In addressing issues under the problem resolution process, the Health Care Options Program, the department's Ombudsman, and the plan shall perform these functions in a manner consistent with cultural and linguistic requirements prescribed by the contract between the plan and the department.

53893. Medi-Cal Managed Care Ombudsman.

(a) The department may designate a Medi-Cal Managed Care Ombudsman. The Ombudsman shall provide Medi-Cal beneficiaries access to a service which investigates and resolves complaints about managed care plans by, or on behalf of, Medi-Cal beneficiaries.

(b) The duties of the Ombudsman shall include, but not be limited to the following:

(1) Encouraging beneficiaries to avail themselves of the opportunity to obtain health care through Medi-Cal managed care plans.

(2) Assisting beneficiaries by removing inappropriate barriers to accessing care.

(3) Educating and informing managed care plans of the specific needs of Medi-Cal beneficiaries.

(4) Educating beneficiaries on how to use the managed care system effectively.

53894. Notice to Members of Plan Action to Deny, Defer or Modify a Request for Medical Services.

(a) Each plan shall provide members with a notice of an action taken by the plan to deny a request by a provider for any medical service. Notice in response to an initial request from a provider shall be provided in accordance with this section. Notice in response to a request for continuation of a medical service shall be provided in accordance with section 51014.1. Notice of denial of a medical service shall not be required in the following situations:

(1) The denial is a denial of a request for prior authorization for coverage for treatment that has already been provided to the member.

(2) The denial is a non-binding verbal description to a provider of the services which may be approved by the plan.

(3) The denial is a denial of a request for drugs, and a drug identical in chemical composition, dosage, and bioequivalence may be obtained through prior authorization from the plan or from the list, established by the plan, of drugs available without prior authorization from the plan.

(b) Each plan shall provide members with a notice of deferral of a request by a provider for a medical service. Notice of the deferral shall be delayed for 30 days to allow the provider of the medical services time to submit the additional information requested by the plan and to allow time for the plan to make a decision. If, after 30 days from the

plan's receipt of the request for prior authorization, the provider has not complied with the plan's request for additional information, the plan shall provide the member notice of denial pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the plan shall take appropriate action on the request for prior authorization as supplemented by the additional information, including providing any notice to the member.

(c) Each plan shall provide members notice of modification of a request by a provider for prior authorization. Notice in response to an initial request from a provider shall be provided in accordance with this subdivision. Notice in response to a request for continuation of a medical service shall be provided in accordance with section 51014.1. Notice of modification pursuant to this subdivision shall not be required in the following situations:

(1) Each plan may modify a request for durable equipment without notice, as long as the substituted equipment is capable of performing all medically significant functions that would have been performed by the requested equipment.

(2) Each plan may modify the duration of any approved therapy or the length of stay in an acute hospital inpatient facility without notice as long as the plan provides an opportunity for the provider to request additional therapy or inpatient days before the end of the approved duration of the therapy or length of stay.

(d) The written notice of action issued pursuant to subdivisions (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

(1) The action taken by the plan.

(2) The reason for the action taken.

(3) A citation of the specific regulations or plan authorization procedures supporting the action.

(4) The member's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the member may be either:

1. Self represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limit for requesting a fair hearing.

(e) For the purposes of this section, medical services means those services that are subject to prior authorization under the plan's authorization procedures.

(f) The provisions of this section apply only to medical services that are covered in the contract between the Department and the plan.

(g) The provisions of this section do not apply to the decisions of providers serving plan members when prior authorization of the service by the plan's authorization procedures is not a condition of payment to the provider for the medical service.

53895. Information to New Members.

(a) The plan shall send information to new members, as described below, by the seventh day of the first month of enrollment in the plan by the new member and annually thereafter.

(b) Each plan shall provide to each member in writing, in addition to those items of information contained in the Welfare and Institutions Code, section 14406, the following information, as approved by the department:

(1) The plan name and the address and telephone number within the plan's service area where member services are available.

(2) The effective date of enrollment.

(3) A description of all available services and an explanation of any service limitations, exclusions from coverage or charges for services, when applicable.

(4) An explanation of how to use the fee-for-service system when Medi-Cal covered services are excluded or limited under the plan and how to obtain additional information.

(5) Information on the availability of transitional Medi-Cal eligibility and how the member may apply for this program.

(6) The name, telephone number, and service site address of the primary care provider selected by the member or instructions to select a primary care provider within thirty days and that failure to timely select a primary care physician will result in the member being assigned a primary care provider by the plan, in accordance with section 53890. The plan shall notify the primary care provider of selection by or assignment of the eligible beneficiary within ten days of selection or assignment.

(7) Procedures for changing the member's primary care provider and an explanation that the member can make this change at any time.

(8) Information concerning any non-medical transportation services available to the member from the plan and through the local EPSDT and CHDP programs, and how to obtain such services.

(9) The appropriate use of health care services in a managed care system and the contributions the member can make toward the maintenance of the member's own health, including the value of scheduling an initial health assessment appointment.

(10) An explanation of the member's right to request a fair hearing under Welfare and Institutions Code section 10950, et seq. without going through the plan's grievance procedures when a health care service requested by the member or a provider has not been provided.

(11) Information on the availability of and procedures for obtaining services at Federally Qualified Health Centers and Indian Health Services facilities.

(12) Information on the member's right to seek family planning services from any provider eligible to provide family planning services under the Medi-Cal program, including providers outside the plan's provider network, and a description of those services.

(13) Information on the member's eligibility for nurse midwife and nurse practitioner services and how to obtain these services.

(14) Information concerning the provision and availability of services covered under the CCS program from providers outside the plan's provider network and how to access these services.

(15) An explanation of the expedited disenrollment process for members meeting the criteria in section 53889(j).

(16) Information on how to obtain minor consent services through the plan, and an explanation of those services.

(17) A description of the Medi-Cal Managed Care Ombudsman Program and the Department of Managed Health Care's Office of Patient Advocate, including the toll-free telephone numbers for each.

53896. Annual Information to Members.

Each plan in a designated region shall revise, if necessary, and distribute the information specified in section 53895(a) to each member or the member's family unit at least once every twelve months.

53897. Notification of Changes in Services.

Each plan in a designated region shall revise, obtain the approval of the department, and distribute the information specified in section 53895(a) at least thirty days prior to any changes which the plan makes in services provided or in the locations at which services may be obtained, to each member affected by that change. Notification shall be provided at least fourteen days prior to any changes in cases of unforeseeable circumstances.

53898. Information for Departmental Dissemination.

Each plan in a designated region shall furnish the department and the Health Care Options Program the information required in section 53895(a), as it changes and upon request, for dissemination to prospective members.